

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

19839

*23 1930*

**PLACE OF DEATH**

County Jefferson Registration District No. 421 File No. \_\_\_\_\_  
 Township Shelburne Primary Registration District No. 5575 Registered No. 60  
 City St. Louis St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Unknown Boy  
 (a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward. \_\_\_\_\_  
 (Usual place of abode) (If nonresident, give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX** Male **4. COLOR OR RACE** White **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** (write the word)

**5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF**

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)**

**7. AGE** YEARS MONTHS DAYS **IF LESS than 1 day,** \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
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**8. OCCUPATION OF DECEASED**

- (a) Trade, profession, or particular kind of work
- (b) General nature of industry, business, or establishment in which employed (or employer)
- (c) Name of employer

**9. BIRTHPLACE (CITY OR TOWN)** \_\_\_\_\_ (STATE OR COUNTRY) Unknown

**10. NAME OF FATHER**

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)** \_\_\_\_\_ (STATE OR COUNTRY) Unknown

**12. MAIDEN NAME OF MOTHER**

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)** \_\_\_\_\_ (STATE OR COUNTRY) Unknown

**14. INFORMANT** \_\_\_\_\_ (Address)

**15. FILED** \_\_\_\_\_, 19 \_\_\_\_\_ **REGISTRAR**

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** \_\_\_\_\_ 19 \_\_\_\_\_

**17. I HEREBY CERTIFY, That I attended deceased from** \_\_\_\_\_, 19 \_\_\_\_\_, to \_\_\_\_\_, 19 \_\_\_\_\_, that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19 \_\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

**THE CAUSE OF DEATH WAS AS FOLLOWS:**

Asphyxiation  
183  
 \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

**CONTRIBUTORY (SECONDARY)** \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

**18. WHERE WAS DISEASE CONTRACTED** \_\_\_\_\_ IF NOT AT PLACE OF DEATH \_\_\_\_\_

**DID AN OPERATION PRECEDE DEATH?** \_\_\_\_\_ DATE OF \_\_\_\_\_

**WAS THERE AN AUTOPSY?** \_\_\_\_\_

**WHAT TEST CONFIRMED DIAGNOSIS?** \_\_\_\_\_ (Signed) J. H. Hensler, M. D.

*Justice of the Peace acting as Coroner*  
 \*State the DISEASE CAUSING DEATH, and the cause thereof, giving state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. NO

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL** Gravel Cemetery **DATE OF BURIAL** 6/19/30

**20. UNDERTAKER** Trink Funeral Co. Festus **ADDRESS** \_\_\_\_\_

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*mo*

